Marin HIV/AIDS Health Services Planning Council
Membership Application Form
2004/05

The federal funding for Marin's HIV/AIDS-related services, the CARE Act, requires that the Marin HIV/AIDS Health Services Planning Council reflect the community it serves, particularly the consumers of CARE-funded services. Demonstrating that commitment, we have set the following goals for membership:

- **33% of members should be consumers of CARE-funded services and unaffiliated with any CARE-funded agency**
- **at least 51% of membership should be people living with HIV disease (PLWH.)**

The primary responsibilities of Council members include: establishing methods for obtaining input on community needs and priorities; developing a comprehensive plan for HIV health services; determining service category priorities; and making recommendations for the allocation of funds based on the priorities previously identified.

Members of the Council will be required to attend a Council Orientation, as well as attend one Council and one Committee meeting (as needed) each month. In order to facilitate the participation of persons living with HIV/AIDS, the attendance requirement is flexible for those individuals. Council member are appointed for a term of three years with a possibility of appointment for one additional term. The Planning Council operates under the auspices of the Marin County Department of Health and Human Services.

Individuals interested in being considered for membership should complete and mail or FAX the attached form to:

Dr. Larry Meredith, Director
Marin County Department of
Health and Human Services
20 N. San Pedro Rd., Suite 2028
San Rafael, CA 94903
Attention: Kelly Litz
FAX number: (415) 507-4059

All application forms will be submitted to the Review Panel for consideration.

For any additional information, contact Sparkie Spaeth at (415) 507-4145 .

Name:			
	First	Middle	Last

Title (if any):

Address:		
City	State	Zip

Contact Info:

Home Phone:	Work Phone:
Cell Phone:	Other:

Email:

Category of Representation (check all that apply to you):

	Individuals living with HIV disease or AIDS
	Affected communities; including populations hard-hit with HIV disease and historically underserved groups
	Health care providers; including federally qualified health centers
	Community-based organizations and AIDS service organizations
	Social Service providers
	Mental Health providers
	Substance Use/Abuse providers
	Housing and Homeless Services providers
	HIV Prevention Service providers
	Local public health agencies; San Francisco, San Mateo or Marin
	Hospital planning agencies or health care planning agencies
	HIV+ Former Prisoners and/or their representatives
	State Medicaid agency
	State agency administering the program under Title II
	Title III grantees
	Title IV grantees or organizations serving youth, children and/or families dealing with HIV disease
	Grantees of other federal HIV programs such as AETC, Dental, SPNS, and HOPWA
	Non-elected community leaders

Demographics (check the best responses for you):

Age: _____ ❑ Decline to state

Gender: ❑ Male ❑ Female ❑ Transgender

*HIV status: ❑ HIV+ ❑ HIV - ❑ Don't know ❑ Decline to state

Sexual Orientation: ❑ Gay ❑ Lesbian ❑ Bisexual

❑ Heterosexual ❑ Decline to state

Race/Ethnicity:
❑ African American/Black
❑ Asian
❑ Caucasian/White
❑ Pacific Islander/Native Hawaiian
❑ Latino/a
❑ Native American/ Alaska Native
❑ Mixed, specify:_____
❑ Other: _____

**Please note that disclosure is not required.*

Consumer Status:

	Current consumer of CARE-funded services (within past year)
	Past consumer of CARE-funded services
	Consumer of HIV-related services; unsure if CARE-funded or not
	Not a consumer/ not eligible for services

Please answer the following questions as completely as possible:

1. *If you are someone who has used any HIV services in the past year, please tell us what those services were.*

2. *Have you had any experience in using, providing or evaluating services for persons living with HIV disease? If so, please describe.*

3. *What particular skills or expertise would you bring to the Planning Council?*

4. *Have you had any experience participating in community planning, health planning, or other similar group planning processes? If so, please describe.*

5. *Please provide contact information for 2 references we may contact regarding your application to participate on the CARE council.*

Name:

Title:

Agency:

Phone:

Email:

Name:

Title:

Agency:

Phone:

Email:

6. *Please list any and all current activities you are engaged in related to HIV/AIDS service providers or organizations, such as Boards of Directors, Consultant work, Staff work, Advisory Boards and volunteer work.*

7. *Why are you interested in becoming a Planning Council member?*

8. *Is there any additional information you would like us to consider when reviewing your application?*

Signature

By signing this Application Form I certify that all information contained herein is true and accurate to the best of my understanding. I also certify that I have read and understand the membership requirements outlined on Page 1 of this form and, if accepted for membership, will fulfill all membership requirements as put forth in the HIV Health Services Planning Council's bylaws.

Date Submitted: _____

Signature: _____
Signature Required

Please return by FAX or Mail – *see information on Page 1*
If possible, please attach a current resume to this Nomination Form for our files.
Additional materials may also be attached and submitted for consideration.